



APPLICATION FOR FINANCIAL AND/OR EMOTIONAL SUPPORT

Do I qualify?

We can consider applications on behalf of single mothers with breast cancer who meet the following conditions:

- you have breast cancer, or are still affected by your illness or treatment
- you have dependent children under the age of 21
- your savings and investments are no more than: £5,000 GBP, \$10,000 USD or \$12,500 AUD
- your household has a weekly income of less than £100GBP, \$200 USD or \$230 AUD for each person after paying the mortgage or rent, Council Tax, insurance, child maintenance / child support / family court order and utilities.

Please complete in BLOCK CAPITALS in BLACK ink.

Name of Applicant	
Address of Applicant	<p>.....</p> <p>.....</p> <p>..... Zip Code</p>
Home Tel	
Work Tel	
Mobile Tel	
Email address	
D.O.B	

Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
No. of dependant Children (Inc. their D.O.B.)	
Is the father involved in the upbringing of your children?	<input type="checkbox"/> Financially <input type="checkbox"/> Custodial Please explain custodial arrangements:

Are you currently employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you receiving benefits*?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is your current monthly income? Please attach your most recent paycheck or benefits claim	

*Benefits - This refers to social security, welfare or any other state related income



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Dr to Complete:

Patients Name	
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I hereby certify that the above named patient has breast cancer
Treated with:

1. Chemotherapy	<input type="checkbox"/>
2. Radiotherapy	<input type="checkbox"/>
3. CTx & RTx	<input type="checkbox"/>
4. Surgery	<input type="checkbox"/>

Does the patient have metastatic disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Organs involved	<input type="checkbox"/> Bone	<input type="checkbox"/> Lungs	<input type="checkbox"/> Other
Are they receiving Palliative care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Practice / Hospital address:	
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Name of Dr: (BLOCK CAPITALS)	Practice / Hospital Stamp
Registration number:	
Signed: Dated:	

I hereby authorize the release of this information to Bouncing for Breast Cancer Inc. In addition Bouncing for Breast Cancer Inc. may contact my doctor directly should they require further information.	
Signed: (Applicant)	Dated:

Bouncing for Breast Cancer Inc.
P.O. Box 646
Brooklyn Park, SA 5032
Australia

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08 7123 2301
International
+61 8 7123 2301

If you are a single mom that needs our help, email us at: support@bouncingforbreastcancer.org
For all other enquiries:
info@bouncingforbreastcancer.org